

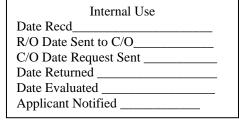
State of Idaho Emergency Medical Services Bureau Provider Application Form



Level Applied For: First Respo	onder EMT-Basic Advance	ced EMT Para	medic				
Type:							
☐ Direct Bill my Agency - Agency Name ☐ Reinstatement ☐ Reversion ☐ Ambulance Rating (complete back) ☐ Reciprocity							
	ersion Amoulance Rating (complete	е баск) кестрго	ocity				
Applicant Information:							
Social Security # Date of Birth / / Drivers License # DL State							
Name				Gender F M			
Last Name	First Name	Middle I	Name/Initial				
Mailing Address							
City			County				
Iome Phone # Cell Phone #							
E-Mail Address	Circle the nignest level of e	education: GED Hig	gn School Diploma C	ollege: 1 2 3 4 5 6 / 8			
Affiliation:							
Agency Name			Agen	ncy License #			
Agency Chief/Director/President							
	ature		Printed Name				
Additional Licensed EMS Affiliations:							
Check all circumstances in which you will use this certification: Volunteer True Full Time							
	ompensated	☐ Part Time					
Have you ever applied for, been denied or received an EMS certification or licensure in any other state? Yes \[\] No \[\]							
If yes, complete an <i>Idaho EMS Certification Verification Request</i> form for each state you applied for or ever held an EMS certification / licensure.							
Applicant Signature:							
Applicant Signature: I hereby affirm the information herein is true and correct, and that I meet all requirements for EMS certification as established by the State of Idaho.							
Signature of Applicant		Date signed					
For Bureau Use Only							
Received in RO		First Respond	ler and Basic	Advanced and Paramedic			
	Cert. Fee Rcvd Date	Test Date	Expiration	Test Date Expiration			
	Cash – Receipt #	10/05-03/06 04/06-09/06	3/31/2009 9/30/3009	10/06-03/07 3/31/2009			
	Check #	10/06-03/07	3/31/2010	04/07-09/07 9/30/2009 10/07-03/08 3/31/2010			
	M.O. #	04/07-09/07	9/30/2010	04/08-09/08 9/30/2010			
Received in C&L	DB - Agency	10/07-03/08	3/31/2011	10/08-03/09 3/31/2011			
		04/08-09/08 10/08-03/09	9/30/2011 3/31/2012	04/09-09/09 9/30/2011 10/09-03/10 3/31/2012			
	Process Date	04/09-09/09	9/30/2012	04/10-09/10 9/30/2012			
		10/09-03/10	3/31/2013	10/10-03/11 3/31/2013			
		04/10-09/10 10/10-03/11	9/30/2013 3/31/2014	04/11-09/11 9/30/2013			
		10/10-03/11	3/31/2014	10/11-03/12 3/31/2014			

IDAHO EMS CERTIFICATION VERIFICATION REQUEST

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First	Last		M.I.
SO KNOWN AS:			
Alias, Ma	iden or Nicknames		
AILING ADDRESS:City			
City		State	Zip
AHO EMS AGENCY OF PRIN	MARY AFFILIATION:		
Authorization	n to release information to th	e IDAHO EMS BUREAU	J
ereby authorize the state of		EMS regula	
Authorization hereby authorize the state of gency to furnish the information		EMS regula	
hereby authorize the state of		EMS regula	ntory credentialing
nereby authorize the state ofency to furnish the information	requested on Page 2 of this o	EMS regula	ntory credentialing on Date







APPLICANT NAME	
APLLICANT DATE OF BIRTH	APPLICANT SS#
THIS FORM MUST BE COMPLETED BY THE STATE	TE EMS REGULATORY CREDENTIALING AUTHORITY
1. STATUS OF CERTIFICATION/LICENSURI	E
EMS LEVEL:	
CERTIFICATE / LICENSE #:	
EXPIRATION DATE:	
2. HAS YOUR STATE TAKEN ANY DISCIPLING IN A SUSPENSION, PROBATION CERTIFICATION OR LICENSURE? YES NO IF YES, PLEASE DESCRIBE (Use Attachment if the supersystem)	N, REVOCATION OR DENIAL FOR EMS
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3. IS THIS INDIVIDUAL CURRENTLY UNDE	CR INVESTIGATION BY YOUR AGENCY?
IF YES, UPON COMPLETION OF INVESTIGAT OF THE OUTCOME AND ANY DISCIPLINARY	TION, PLEASE NOTIFY THE IDAHO EMS BUREAU ACTION TAKEN.
I hereby certify that the above information is true as	nd correct recorded by this office.
Signature	Name (print)
Title	
Agency Name	
Date	
Please fax Page 2 to 208-334-4015 or mail to: Idaho EMS Bureau 590 W. Washington St. Boise, ID 83702	State Board or Seal

The Idaho EMS Bureau thanks you for your timely response and participation in completing this form.